SERFF Tracking Number:	*TRST-127911601*	*State:*	*Arkansas*
Filing Company:	*Trustmark Insurance Company*	*State Tracking Number:*	*50534*
Company Tracking Number:	*11.00675*		
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*Claim-Appeal Notice*		
Project Name/Number:	*/*		

Filing at a Glance

Company: Trustmark Insurance Company

Product Name: Claim-Appeal Notice	SERFF Tr Num: TRST-127911601	State: Arkansas
TOI: H16I Individual Health - Major Medical	SERFF Status: Closed-Approved-Closed	State Tr Num: 50534
Sub-TOI: H16I.005A Individual - Preferred Provider (PPO)	Co Tr Num: 11.00675	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Author: Julia Swanson	Disposition Date: 12/21/2011
	Date Submitted: 12/20/2011	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Pending
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type: Individual
Overall Rate Impact:	Filing Status Changed: 12/21/2011
	State Status Changed: 12/21/2011
Deemer Date:	Created By: Julia Swanson
Submitted By: Lisa Sayerstad	Corresponding Filing Tracking Number:

PPACA: Grandfathered Immed Mkt Reforms
PPACA Notes: null
Filing Description:
RE; FORM NUMBER: CLAIM-APPEAL NOTICE AR

Dear Sir or Madam:

In this filing please find the above listed form for your review and approval for use in Arkansas in accordance with AR Bulletin 10-2011 - Rule 76, External Review Regulation. With this filing we have incorporated procedures that are

SERFF Tracking Number:	*TRST-127911601*	*State:*	*Arkansas*
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TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*Claim-Appeal Notice*		
Project Name/Number:	*/*		

required per state law as well as to accommodate changes required by Health Care Reform. This form is new and will not replace any forms currently in use. Upon approval, this form will be used with all individual major medical forms previously approved by Arkansas.

The form is in final printed format as issued from a laser printer. We, however, use different computer publishing systems. Therefore, the actual issued form may have a different font style than the submitted form. As a result, page breaks may occur at different lines and line wording may not match up exactly. The wording and its order, however, will remain identical. We do not anticipate refiling for such font style variation.

Thank you for your time and effort with regard to this filing. If you have any questions, please contact me at 800-666-6977, extension 34203 or at julia.swanson@trustmarkins.com.

Company and Contact

Filing Contact Information

Julia Swanson, Compliance Analyst	Julia.Swanson@trustmarkins.com	
400 Field Drive	847-283-2403 [Phone]	
Lake Forest, IL 60045	847-615-3872 [FAX]	

Filing Company Information

Trustmark Insurance Company	CoCode: 61425	State of Domicile: Illinois
400 Field Drive	Group Code: 276	Company Type:
Lake Forest, IL 60045	Group Name:	State ID Number:
(800) 666-6977 ext. [Phone]	FEIN Number: 36-0792925	

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	Yes
Fee Explanation:	Illinois domicilary state - $50.00 for form filing.
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Trustmark Insurance Company	$50.00	12/20/2011	54703040

SERFF Tracking Number:	*TRST-127911601*	*State:*	*Arkansas*
Filing Company:	*Trustmark Insurance Company*	*State Tracking Number:*	*50534*
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Product Name:	*Claim-Appeal Notice*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	12/21/2011	12/21/2011

SERFF Tracking Number:	*TRST-127911601*	*State:*	*Arkansas*
Filing Company:	*Trustmark Insurance Company*	*State Tracking Number:*	*50534*
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TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*Claim-Appeal Notice*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 12/21/2011
Implementation Date:
Status: Approved-Closed
HHS Status: HHS Approved
State Review: Reviewed-No Actuary
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*TRST-127911601*	*State:*	*Arkansas*
Filing Company:	*Trustmark Insurance Company*	*State Tracking Number:*	*50534*
Company Tracking Number:	*11.00675*		
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*Claim-Appeal Notice*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Form	Notice Claim and Appeal Rights	Approved-Closed	Yes

SERFF Tracking Number:	*TRST-127911601*	*State:*	*Arkansas*
Filing Company:	*Trustmark Insurance Company*	*State Tracking Number:*	*50534*
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TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*Claim-Appeal Notice*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 12/21/2011	CLAIM-APPEAL NOTICE AR	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Notice Claim and Appeal Rights	Initial		43.700	Claim-Appeal Notice AR.pdf

NOTICE OF YOUR CLAIM AND APPEAL RIGHTS

For purposes of this notice an adverse determination is a determination that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested health care service is therefore denied, reduced, or terminated under Your contract.

How We Pay Claims
Upon receipt of a claim, We will evaluate if benefits are available under this Certificate. All claims, electronic and paper, will be reviewed and processed in the order they are received in Our office in accordance with state and federal legislative requirements[and network contract allowance].

The time periods for processing a claim and providing additional information vary; depending on the type of claim at issue as described below.

Post-Service Claims
Post-service claims are those filed for payment of benefits after medical care has been received.

We will notify the Covered Person, within [30] days after receiving a claim, that the claim has been received and what your benefits are determined to be.

If more than [30] days are needed to determine benefits due to reasons beyond Our control, We will notify the Covered Person within that [30] day period that more time is needed to determine benefits. But, in any case, We may not take more than [45] days to determine your benefits.

If the Covered Person does not submit all the necessary information, [We will provide notice explaining what information is needed. The Covered Person has [45] days to provide the information needed to process the claim. The time period during which We are waiting for receipt of the necessary information does not count toward the timeframe in which We must make a benefit determination. If the Covered Person does not provide the requested information within the [45] day period;]the claim will be denied. The Covered Person may submit such claim for reconsideration, with the requested information, within the timeframe specified below in *How To Appeal a Claim Decision*.

Pre-service Claims
Pre-service claims are those claims that require notification or approval prior to receiving medical care.

We will notify the Covered Person, within [15] days after receiving a claim, that the claim has been received and what the benefits are determined to be.

If We need more than [15] days to determine benefits, due to reasons beyond Our control, We will notify the Covered Person within that [15] day period that more time is needed. But, in any case, We may not take more than [30] days to determine benefits.

If the Covered Person does not submit all the necessary information, We will provide notice within [5] days explaining the additional information needed. The Covered Person has [45] days to provide the information necessary to process the claim. The time period during which We are waiting for receipt of the necessary information does not count toward the time frame in which We must make a benefit decision. If the Covered Person does not provide the requested information within the [45] day period; the claim will be denied. The Covered Person may submit such claim for reconsideration, with the requested information, within the timeframe specified below in *How To Appeal a Claim Decision.*

Urgent Claims that Require Immediate Attention
Urgent claims are those claims that require notification or approval prior to receiving medical care, where delay in treatment could:

- Seriously jeopardize the Covered Person's life or health; or
- Seriously jeopardize the Covered Person's ability to regain maximum function; or
- In the opinion of a Doctor with knowledge of the Covered Person's medical condition, could cause severe pain.

In these situations We must notify the Covered Person, within [72] hours after receiving a claim, that the request has been received and what benefits are determined to be.

If the Covered Person does not submit all the necessary information, We will notify the Covered Person by fax or telephone within [24] hours of the additional information needed. The Covered Person will have [48] hours to provide Us with the information necessary to process the claim. The Covered Person will be notified of a benefit decision no later than [48] hours after Our receipt of the requested information. If the requested information is not received within such [48] hours, a decision will be made based on the information available.

Concurrent Care Claims
If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and the Covered Person's request to extend the treatment is an urgent claim as defined above, We will make a determination within [24] hours of the request; provided the request is made at least [24] hours prior to the end of the approved treatment. If the request for extended treatment is not made at least [24] hours prior to the end of the approved treatment, the request will be treated as an urgent claim and decided according to the timeframes described above.

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and the Covered Person's request to extend treatment is a non-urgent circumstance, the request will be considered according to post-service or pre-service timeframes described above; whichever applies.

Notice of Benefit Decision
If the claim is denied in whole or in part, a notice of Adverse Benefit Determination will include: identification of the claim involved; the reason for the decision; the Certificate provisions relied upon in making the decision; an explanation of the Covered Person's rights to appeal and the process for making an appeal; the availability of and contact information for Our office and other agencies and offices available to assist with the appeals process; and any additional information required by law.

What to Do if You Disagree With Our Decision

This section outlines the Covered Person's rights to file an appeal.

How to Appeal a Claim Decision – Internal Appeal Process
The Covered Person may appeal a claim decision. The Covered Person's appeal rights will be forfeited if the Covered Person fails to submit the appeal to Us, in writing to the address identified below, within [180] days from receipt of the claim decision.

All Covered Persons who are dissatisfied with a first level appeal review will have the right to request a second level appeal review. The second level appeal request must be submitted to Us in writing within [60] days from receipt of the first level appeal decision. All appeals will be reviewed by someone with the appropriate expertise and who was not involved with the original decision.

We will provide the Covered Person with a full and fair review of the claim appeal. If We uphold a claim decision on the second level of appeal, We will provide the Covered Person with any new or additional evidence that was considered, relied upon, or generated by Us in connection with the claim review in advance of the date on which the notice of a final internal benefit determination is provided.

The written appeal should include: the Covered Person's name and identification number from the identification card; the basis for the appeal; and any supporting documentation. If the appeal relates to a claim payment decision, the written appeal should also include the date(s) of medical service(s) and the applicable health care provider's name.

Faxed or written appeals must be sent to:

[Trustmark Insurance Company
Grievance Review
8324 South Avenue
Boardman, OH 44512
Fax (330) 965-7599]

Timeframes for Internal Appeals
The Covered Person will be provided notification of Our decision on the appeal as follows:

- Urgent care claims: We will notify the Covered Person of Our decision within [72] hours from Our receipt of the appeal. Depending on the nature of the review, the Covered Person may have the right to request an expedited external review. Refer to *Request For Expedited External Review* below.
- Pre-service claims: For both the first and second level of appeal, We will notify the Covered Person, in writing, of Our decision within [15] days from Our receipt of the appeal.
- Post-service claims: For both the first and second level of appeal, We will notify the Covered Person, in writing, of Our decision within [30] days from Our receipt of the appeal.

If the Covered Person fails to submit the written appeal to the correct address or fax number, We reserve the right to deny the request and will inform the Covered Person of such denial. We may also choose to process the request, however the timeframe for processing the appeal will not begin to run until the correspondence is received by the Grievance Review area of Our office.

Once the Covered Person has exhausted both the first and second level appeals, the Covered Person will be informed of the right to request an external review by an independent review organization.

How to Appeal a Decision – External Review Process
The notice of a final internal Adverse Benefit Determination will include detailed information about a Covered Person's right to request an external review. The notice will also include the process for making such request. With respect to the external review process, an Adverse Benefit Determination shall only include those determinations that involve medical judgment, including, but not limited to medical necessity; appropriateness; experimental/investigational; health care setting; level of care; or effectiveness of a covered benefit and rescissions of coverage.

The Covered Person or the Covered Person's authorized representative will have [4 months] after the date of the Adverse Benefit Determination or final internal Adverse Benefit Determination to request an external review with the Commissioner.

The Covered Person or the Covered Persons representative may file a request for external review to:

Arkansas Insurance Commissioner
1200 West 3rd Street
Little Rock, AR 72201
Or by calling 1-800-282-9134

Within 1 business day after the date of receipt of a request for external review, the Commissioner will send a copy of the request to Us.

The Commissioner will assign an independent review organization (IRO) to review the request within 1 business day of receipt of the preliminary review from Us. The Commissioner will also notify Us and the Covered Person of the acceptance of the review and the name of the IRO. The notice will include instructions for submitting additional information to the IRO. Any additional information must be submitted within 5 business days of receipt of the notice.

We will provide the IRO all information considered when making the adverse determination, within 5 business days of receipt of the notice from the Commissioner. If We do not provide the required information, the IRO may decide to reverse the adverse decision and terminate the external review. The IRO will notify the Covered Person or the Covered Person's authorized representative, Us, and the Commissioner within 1 business day of reversing the decision.

The assigned IRO will review all of the information received. Upon receipt of any information submitted by the Covered Person or the Covered Person's authorized representative, the assigned IRO will forward the information to Us within 1 business day.

Upon Our receipt of the information, We may reconsider Our adverse determination or final adverse determination that is the subject of the external review. Our reconsideration of Our adverse determination or final adverse determination will not delay or terminate the external review. The external review may only be terminated if We decide, upon completion of Our reconsideration, to reverse Our adverse determination or final adverse determination and provide coverage or payment for the health care service that is the subject of the adverse determination or final adverse determination.

Within 1 business day after making the decision to reverse Our adverse determination or final adverse determination, We will notify the Covered Person, the Covered Person's authorized representative, the assigned IRO, and the Commissioner in writing of Our decision. The assigned IRO will terminate the external review upon receipt of the notice from Us.

Once an independent review organization accepts the request for external review, the independent review organization will have [45 days] to provide written notice of its decision to the Covered Person or the Covered Person's authorized representative, Us and the Commissioner.

Request For Expedited External Review

The Covered Person or the Covered Person's authorized representative may request an expedited external review with the Commissioner. This may be done at any time following receipt of an Adverse Benefit Determination (even if the person has not exhausted the internal appeal process). However, such request may only be made if the Adverse Benefit Determination involves a medical condition for which the timeframe to complete an internal appeal or the timeframe to complete a standard external review seriously jeopardize the Covered Person's life; health; or ability to regain maximum function.

In the event of an experimental/investigational treatment adverse determination the Covered Person or the Covered Person's authorized representative may make an oral request for an expedited external review of the adverse determination or final adverse determination if the Covered Person's treating physician certifies, in writing, that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated.

Upon receipt of a request for an expedited external review, the Commissioner will immediately send a copy of the request to Us. Immediately upon receipt of the request, We will determine whether the request meets the reviewability requirements. We will immediately notify the Commissioner and the Covered Person and the Covered Person's authorized representative of Our eligibility determination.

Upon receipt of the notice that the request meets the reviewability requirements, the Commissioner will immediately assign an IRO to conduct the expedited external review and will immediately notify Us of the name of the assigned IRO. In reaching a decision, the assigned IRO is not bound by any decisions or conclusions reached during Our utilization review and internal appeal process.

In the event of an expedited external review, the external review will be conducted on an expedited basis and a decision will be rendered by the independent review organization and communicated to the Covered Person, the Covered Person's authorized representative, Us and the Commissioner within [72 hours] after the independent review organization receives the request. If the decision was not communicated by writing, the assigned IRO will provide written confirmation to the Covered Person, the Covered Person's authorized representative, Us and the Commissioner within 48 hours after the date of providing its decision.

Preliminary Review

Within [5] business days of receipt of the request for an external review from the Commissioner (or immediately in the case of a request for an expedited external review); We will determine whether:

a. The Covered Person had coverage at the time the service was provided or requested;
b. The service provided was a covered service, medically necessary, or appropriate for the condition;
c. The Covered Person's treating physician has certified that the services or treatments have not been effective in improving the condition of the Covered Person;
d. There is no available standard health care service or treatment under the Covered Person's coverage that is more beneficial than the recommended or requested service or treatment;
e. External review is available based on the reason for the Adverse Benefit Determination;
f. The Covered Person exhausted the internal appeals process, if required; and
g. The Covered Person provided all information needed to process the external review.

Within [1] business day of the preliminary review determination (or immediately in the case of a request for an expedited external review), We will send written notice to the Commissioner and Covered Person (or their authorized representative) as to whether the request has been accepted. If the Covered Person is not eligible for external review, the written notice will explain the reason for the ineligibility, that the ineligible external review request may be appealed to the Commissioner; and provide contact information for the Employee Benefits Security Administration.

If the request for external review is not complete, the written notice will describe the information or materials needed and will give the Covered Person until the end of the [4 month] period or [48] hours, whichever is later, to provide such information or materials.

Independent Review Organization

If the independent review organization reverses Our decision, We will pay the claim; or otherwise immediately provide coverage consistent with the independent review organization's determination. The independent review organization's decision is binding on you and Us; except to the extent that other remedies may be available under State or Federal law.

SERFF Tracking Number:	*TRST-127911601*	*State:*	*Arkansas*
Filing Company:	*Trustmark Insurance Company*	*State Tracking Number:*	*50534*
Company Tracking Number:	*11.00675*		
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*Claim-Appeal Notice*		
Project Name/Number:	*/*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	12/21/2011

Comments:

Attachments:

Flesch Score Certification.pdf
Certification of Compliance Reg 19.pdf
Certification of Compliance Reg 49.pdf

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	12/21/2011
Bypass Reason:	N/A. This fiing only contains the Claim-Appeal Notice for a closed block of our individual medical business.		

Comments:

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	12/21/2011
Bypass Reason:	N/A. This fiing only contains the Claim-Appeal Notice for a closed block of our individual medical business.		

Comments:

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	12/21/2011
Bypass Reason:	N/A. This fiing only contains the Claim-Appeal Notice and not coverage for benefits.		

Comments:

		Item Status:	Status Date:

SERFF Tracking Number:	*TRST-127911601*	*State:*	*Arkansas*
Filing Company:	*Trustmark Insurance Company*	*State Tracking Number:*	*50534*
Company Tracking Number:	*11.00675*		
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*Claim-Appeal Notice*		
Project Name/Number:	*/*		

Satisfied - Item: PPACA Uniform Compliance Summary — Approved-Closed — 12/21/2011

Comments:

Attachment:

PPACA Uniform Compliance Summary.pdf

Trustmark
Insurance Companies

Law Department

Phone 847.615.1500
Fax 847.615.3872

Trustmark Insurance Company hereby certifies that the form shown below meets the requirements under Arkansas Admin. Code 054.00.29-5 and A.C.A. § 23-80-206 and that the Flesch reading ease score of the form is as follows:

FORM	FLESCH SCORE
CLAIM-APPEAL NOTICE AR	43.7

December 20, 2011
Date

Sandra J. Przybyszewski

Sandra Przybyszewski
Vice President, Compliance

Certification of Compliance

Trustmark Insurance Company hereby certifies that, to the best of its knowledge and belief, is compliant with the requirements of the Arkansas Insurance Rule and Regulation 19.

December 20, 2011
Date

Sandra Przybyszewski
Vice President, Compliance

Certification of Compliance

Trustmark Insurance Company hereby certifies that, to the best of its knowledge and belief, is compliant with the requirements of the Arkansas Insurance Rule and Regulation 49.

December 20, 2011
Date

Sandra Przybyszewski
Vice President, Compliance

PPACA Uniform Compliance Summary

Please select the appropriate check box below to indicate which product is amended by this filing.

☑ **INDIVIDUAL HEALTH BENEFIT PLANS** ***(Complete SECTION A only)***

☐ **SMALL / LARGE GROUP HEALTH BENEFIT PLANS** ***(Complete SECTION B only)***

This form filing compliance summary is to be submitted with your [endorsement][contract] to comply with the immediate market reform requirements of the Patient Protection and Affordable Care Act (PPACA). These PPACA requirements apply only to policies for health insurance coverage referred to as "major medical" in the statute, which is comprehensive health coverage that includes PPO and HMO coverage. This form includes the requirements for grandfathered (coverage in effect prior to March 23, 2010) and non-grandfathered plans, and relevant statutes. Refer to the relevant statute to ensure compliance. Complete each item to confirm that diligent consideration has been given to each. (*If submitting your filings electronically, bookmark the provision(s) in the form(s) that satisfy the requirement and identify the page/paragraph on this form.*)

***For all filings, include the Type of Insurance (TOI) in the first column.**

☐ Check box if this is a paper filing.

COMPANY INFORMATION

Company Name	NAIC Number	SERFF Tracking Number(s) *if applicable	Form Number(s) of Policy being endorsed	Rate Impact
Trustmark Insurance Company	276-61425	TRST-127911601	CLAIM APPEAL NOTICE AR	☐ Yes ☑ No

PPACA Uniform Compliance Summary

Reset Form

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	*[Sections 2704 and 1255 of the PHSA/Section 1201 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Eliminate Annual Dollar Limits on Essential Benefits Except allows for "restricted" annual dollar limits for essential benefits for plan years prior to January 1, 2014.	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Eliminate Lifetime Dollar Limits on Essential Benefits	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	*[Section 2712 of the PHSA/Section 1001 of PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain
	Explanation:			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services.	*[Section 2713 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26.	*[Section 2714 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Appeals Process – Requires establishment of an internal claims appeal process and external review process.	*[Section 2719 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number: CLAIM APPEAL NOTICE AR			
	Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no,** please explain.
	Explanation:			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child's PCP if the provider is in-network.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			

Reset Form

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	*[Sections 2704 of the PHSA/Section 1201 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Eliminate Annual Dollar Limits on Essential Benefits – Except allows for "restricted" annual dollar limits for essential benefits for plan years prior to January 1, 2014.	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Eliminate Lifetime Dollar Limits on Essential Benefits	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no,** please explain.
	Explanation:			
	Page Number:			
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	*[Section 2712 of the PHSA/Section 1001 of PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services	*[Section 2713 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26. ◊	*[Section 2714 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes**◊ ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Appeals Process – Requires establishment of an internal claims appeal process and external review process.	*[Section 2719 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			

◊ For plan years beginning before January 1, 2014, grandfathered group plans are not required to extend coverage to a child until the age of 26 if such child is eligible to enroll in another employee-sponsored plan

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child's PCP if the provider is in-network.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			